Appendix 9

Completed Sample Prior Authorization Request Form (PA/RF) for Exceptional Supplies, Prior Approval Granted

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE
139

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YYYY

6 SEX
M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
518.81 Resp. Failure

11 DX: SECONDARY
V55.0 Tracheostomy

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6890		8	P	Trach care kit BID	60	XXX.XX
W6890		8	P	Trach suction catheter/every shift	90	XXX.XX
W6890		8	P	Trach tie/secure every 3 days	10	XXX.XX
W6890		8	R	Compressor	30	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start date: 01-01-01
end date: 06-30-01

23 MM/DD/YYYY
DATE

24 I.M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[X] APPROVED

01-01-01
GRANT DATE

06-30-01
EXPIRATION DATE

PROCEDURE(S) AUTHORIZED	QUANTITY AUTHORIZED
W6890 (P) Average daily max $XX.XX	181 days
W6890 (R) Average daily max $XX.XX	181 days

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

12/27/00
DATE

I.M. Nurse Consultant
CONSULTANT/ANALYST SIGNATURE

482-120

Appendix